

Mediating in Healthcare's Clinical Setting: Time for a Course Correction*

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I. INTRODUCTION

In many healthcare organizations, clinicians, patients and families can request an ethics consult when they encounter difficult questions of right and wrong, or are not sure of the best course of action – e.g., end of life decisions or how best to allocate scarce resources. Sometimes the situation embodies genuine moral puzzlement in which thoughtful people, deeply uncertain about what is best, ask for guidance from someone they hope can illuminate the relevant issues and options. More commonly, perhaps, consults are requested amidst conflict: people with firm but opposing convictions ask the bioethicist to weigh in, perhaps to favor one perspective over another. In this sense, conflict resolution has long been integral to clinical bioethics.

After outlining in Part I the role conflict resolution plays in the triage and early resolution of healthcare ethics consults, this Article focuses on one specific type of conflict management: mediation. Introduced into healthcare's clinical setting¹ over two decades ago, mediation has provided an important tool for bioethics consultation. Still, the version of mediation predominant in bioethics introduces important modifications, and these need to be critically examined.

As discussed in Part II, universal standards of mediation include three primary principles of ethics and process: *confidentiality*, *neutrality*, and *self-determination*. As cornerstones of mediation, they are the key to building parties' trust in the mediator and in the mediation process. Without trust there is little chance that people will eventually confide their deeper concerns—the underlying issues that are often pivotal to addressing the real problem, rather than just the superficial, first-blush concerns people offer to those they do not yet trust. At the same time, the very fact that mediators elicit such vulnerable truths carries ethical mandates that are embodied in those same core principles. If a promise of confidentiality helps to elicit that crucial back-story, for instance, it is ethically imperative that such a promise be kept.

Part III critically examines the ways in which "Bioethics Mediation" ("BEM"), the most common version of mediation taught within healthcare's clinical setting, strays significantly from all three core principles. It curtails *confidentiality* by requiring that any information regarding a patient must be passed along to providers, regardless of whether the patient consents. BEM abridges *self-determination*, *inter alia*, by expecting the mediator at least sometimes to enforce an agreement even if one or more parties no longer endorse it. Finally, *neutrality* is infringed as BEM requires mediators

¹ By "clinical setting" is meant the setting in which physicians and other healthcare personnel directly provide patients with services such as diagnosis and treatment of health conditions.

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unilaterally to limit parties' options. Parties will only be permitted to make agreements that lie within the range of "clearly accepted ethical principles, legal stipulations, and moral rules defined by ethical discourse, legislatures, and courts..."² That is, the mediator will not allow parties to choose any option outside those boundaries. Two variations of BEM, "Ethics Facilitation" ("EF") and "Clinical Ethics Mediation" ("CEM"), embrace the same limitation on neutrality, hence share its deficiencies.

Admittedly, parties in any mediation, whether in healthcare or any other setting, are not free to do literally *whatever* they wish. Hence mediators do sometimes need to introduce "reality checks." However, as Part IV discusses, those reality checks generally must emanate from externally authoritative sources such as law, policy, or empirical reality. "Clearly accepted" moral norms will not suffice. That said, such reality checks must be delivered in ways that continue to honor confidentiality, neutrality, and self-determination.

After thus exploring the problems of BEM, EF and CEM, this article proposes in Part V that in healthcare, traditional mediation based on long-standing mediation ethics is needed, not an altered version that violates those values. Although this Article begins with conflict resolution in bioethics, Part V notes that high-quality mediation is helpful well beyond ethics quandaries. Disputes among co-workers, between administration and staff, among leadership, and everywhere else in this complex realm have implications for safety and quality of care, for provider burnout, for patient and family satisfaction. Mediation can help across the spectrum.

That said, mediation in healthcare's clinical setting differs in important ways from the mediation typically seen in litigation. The basics remain the same, yet practical differences of context and logistics suggest differences in style and strategy worth noting. These, too, are briefly explored in Part V.

II. TRIAGE AND EARLY RESOLUTION

Initial requests for ethics consults are typically succinct—a brief summary of a situation plus a question that may or may not be clear. Hence the first task is a kind of triage: clarify with the requester, then gather information from providers, patients, families, medical records, and other sources.

Sometimes the situation turns out to be a miscommunication or a need for further information such that upon clarification, the problem simply

² NANCY NEVELOFF DUBLER & CAROL B. LIEBMAN, BIOETHICS MEDIATION: A GUIDE TO SHAPING SHARED SOLUTIONS 14 (Vanderbilt Univ. Press, rev. and expanded ed. 2011) (2004).

disappears. "I thought the doctor suggested X – I don't want X. But now I realize she proposed Y, and Y is fine." Problem gone. Or a family may simply need to be heard, e.g., to express disappointment that their concerns did not seem to be taken seriously. In these scenarios, conflict resolution skills such as active listening can play a major role in helping parties to hear each other, honor the dignity of each person's perspective and, in the end, make the problem disappear as parties realize no serious disagreement existed, or that a good solution is readily available.

If the problem does not thus disappear, an ethics consult generally can go in two basic directions. Some situations ask for *moral guidance*, while others need *conflict resolution*, and some appear to need some of each.

Moral guidance is in some ways prototypical. Like a traditional medical consult, the ethics consultant gathers information, clarifies questions and analyzes perspectives, often culminating in a recommendation. He or she may endorse a single course of action, or array several acceptable options, or perhaps just rule out some clearly unacceptable alternatives. A request for guidance may reflect genuine moral puzzlement about what is right, or it may stem from a strategy to resolve conflict by asking the ethics consultant to take sides—e.g., to agree that physicians' wish to abate aggressive life support is morally superior to the family's demand for "everything."

Moral guidance is fairly common. Fox et al. found that "[i]n 65% of the hospitals, the ECS [Ethics Consultation Service] made some form of recommendation for 100% of cases On average, ECSs recommended a single best course of action for 46% of cases, described a range of acceptable actions for 41% of cases, and made no recommendation for 13% of cases."³

Other occasions call for conflict resolution. Those who feel pushed often push back, and sometimes parties need help to stop arguing and forge a plan everyone can accept. Diverse formats are available. *Negotiation* (party-to-party problem-solving conversations) is something healthcare providers do routinely—with patients, with each other, with administration, with staff, often to figure out who will do what and when. *Coaching* can also be very useful. A resident⁴ may need help with how to broach a difficult conversation with a patient, or a faculty colleague may want help on how to disclose an error, perhaps using role-play with debriefing to prepare for those conversations. *Informal facilitation* involves helping a group of people to solve a problem or

³ Ellen Fox, Sarah Myers & Robert A. Pearlman, *Ethics Consultation in United States Hospitals: A National Survey*, 7 AM. J. BIOETHICS 13, 18 (2007).

⁴ "Residency" is a period of several years, typically three or more, during which a medical school graduate specializes in a field such as surgery, pediatrics, or internal medicine. "Fellowship" refers to those who have completed residency and have gone on to subspecialize, e.g., in cardiothoracic surgery, pediatric rheumatology, or cardiology.

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reach a common goal by ensuring that everyone can be heard and freely brainstorm until collectively they create a satisfactory plan. *Arbitration* involves choosing a third party, in essence a private judge, who hears the relevant information and issues a decision. Indeed, a moral guidance-type ethics consult is essentially a form of *non-binding arbitration*⁵: "I think you should do X, although the decision is still yours to make."

Mediation, the focus of this article, is assisted negotiation. In one form or another it has been practiced in virtually every society,⁶ from tribal elders, to complex multi-corporation lawsuits, to community mediation centers helping neighbors negotiate noise levels. In mediation, someone who is not part of a dispute helps parties find their own resolution. The mediator does not take sides or steer parties toward a preferred outcome—that would be more like arbitration. Rather, the mediator uses a variety of skills and strategies to help parties figure out for themselves what is at stake, what their own priorities are, and what resolution(s) would be acceptable to everyone.

Thus, mediation is but one tool among others for resolving conflict. That said, when mediation is used, it needs to be done properly. Three basic principles must be honored if parties are to trust the process, trust the mediator, and thereby be able to forge a mutually acceptable, *durable* resolution.⁷

III. CORNERSTONE PRINCIPLES OF MEDIATION

Three cornerstones of successful, ethically sound mediation are:

- (1) confidentiality: "what you say to me in private, stays private";
- (2) neutrality: "I am not here to take sides"; and
- (3) self-determination: "I am not here to tell anyone what to do."

These principles have been endorsed by major organizations, including: (a) the International Ombudsman Association's (IOA's) Code of Ethics,⁸ and (b) the American Arbitration Association (AAA), American Bar

⁵ Ellen Waldman, *Bioethics Mediation at the End of Life: Opportunities and Limitations*, 15 CARDOZO J. CONFLICT RESOL. 449, 451 (2014).

⁶ See generally CHRISTOPHER W. MOORE, THE MEDIATION PROCESS: PRACTICAL STRATEGIES FOR RESOLVING CONFLICT 43–58 (3d ed. rev. 2003).

⁷ In the clinical setting an agreement can sometimes become inoperable for reasons beyond anyone's control. A patient's condition may unexpectedly change, for instance, or new information can markedly change the question. Here the agreement has not failed, but simply been superseded by subsequent developments.

⁸ IOA CODE OF ETHICS (INT'L OMBUDSMAN ASS'N 2007), <https://www.ombudsassociation.org/assets/IOA%20Code%20of%20Ethics.pdf>. The IOA guides the

Association (ABA) and Association for Conflict Resolution (ACR), whose Model Standards⁹ guide mediation of lawsuits both domestically and internationally. Most states have based their own rules of mediation on the AAA/ABA/ACR standards. Note, the ombuds and legal communities did not invent these standards out of whole cloth. Rather, these principles have emerged from longstanding experience regarding how mediation functions best.

Partly these three principles define mediation: the parties themselves, not a judge or arbitrator, decide how they will resolve their issue. Partly, also, they are practical: if the goal is a durable resolution, some approaches work better than others for helping parties to explore their most important issues and determine what sort of resolution is acceptable. And finally, these principles are also ethical mandates. Once a mediator commits to honor them simply by virtue of offering mediation, dishonoring them becomes a broken promise, hence ethically problematic.

A. *Confidentiality: "What you say to me in private, stays private."*

IOA: "The Ombudsman holds all communications with those seeking assistance in strict confidence and does not disclose confidential communications unless given permission to do so."

AAA/ABA/ACR Standard V: "A mediator shall maintain the confidentiality of all information obtained by the mediator in mediation, unless otherwise agreed to by the parties or required by applicable law."

Standard V-B: "A mediator who meets with any persons in private session during a mediation shall not convey directly or indirectly to any other person, any information that was obtained during that private session without the consent of the disclosing person."

In the healthcare setting, conflict often features distrust. A patient, perhaps fearing the physician may disdain him, may withhold sensitive information such as immigration status, medication noncompliance, or drug use. Or perhaps clinician may doubt a colleague's competence, but hesitate to say anything for fear of retaliation. In mediation, a commitment to honor the privacy of each person's information can encourage participants to share

organizational ombuds who provide conflict resolution services, including mediation, in many corporations, universities, medical centers and other organizations.

⁹ MODEL STANDARDS OF CONDUCT FOR MEDIATORS (AM. ARB. ASS'N, ABA & ASS'N FOR CONFLICT RES. 2005) [hereinafter MODEL STANDARDS], https://www.americanbar.org/content/dam/aba/migrated/2011_build/dispute_resolution/model_standards_conduct_april2007.authcheckdam.pdf.

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openly with the mediator. Unearthing those most private undercurrents is often key to forging a resolution that actually addresses the real issues, and which thereby can last over time.

Confidentiality is not just a vehicle for learning the vulnerable truths whose exposure may be prerequisite to understanding the problem and thereby crafting a durable resolution. It is also an ethical imperative. A promise made must be a promise kept.

As in any confidential relationship there are standard exceptions, of course, for child abuse, elder abuse, or imminent threats of serious physical harm. Fortunately, these are rare. More commonly, a mediator might believe certain information would be very helpful to share with the other side. Here, although the mediator can suggest that sharing would be useful and perhaps offer ideas on how it might be framed, the person who owns that information still makes the decision.

B. *Neutrality: "I am not here to take sides"*

Neutrality is at least as important as confidentiality. From the IOA: "The Ombudsman, as a designated neutral, remains unaligned and impartial. . ." And per AAA/ABA/ACR Standard II: "A mediator shall conduct a mediation in an impartial manner and avoid conduct that gives the appearance of partiality;" "[i]mpartiality refers to the absence of bias or preference in favor of one or more negotiators, their interests, or the specific solutions that they are advocating." "If at any time a mediator is unable to conduct a mediation in an impartial manner, the mediator shall withdraw."¹⁰

In the healthcare setting, neutrality is particularly important. Parties frequently have been, metaphorically speaking, in toe-to-toe, knock-down-drag-out conflict, often for a long time. If the mediator crosses the line and starts suggesting who has the superior position or which side ought to prevail, s/he quickly becomes just another pair of fists in the fight. Trust evaporates for the mediator and for the mediation process.

Instead, a mediator who rigorously avoids favoring any party or viewpoint has a fairly good prospect of earning enough trust, eventually, to learn what is really at issue—the back-stories that ultimately fuel the conflict and which will shape any possibility for a durable resolution. The more clearly the mediator is an honest broker, the better the chance that parties' information, layer by layer, will be honest and increasingly detailed.

Neutrality is also a requirement of ethics. Because mediation is

¹⁰ *Id.* Standard II.C. The concept of neutrality or impartiality might better be called "multipartial" or "omnipartial," in that mediators strive to address all parties' issues and interests. MOORE, *supra* note 6, at 53.

fundamentally a voluntary process,¹¹ mediators ordinarily must begin by describing what mediation is and inviting parties into the process. Since that invitation will describe the mediator as impartial (or it is not mediation), any subsequent departure from neutrality can be a breach of promise, an act of dishonesty.

This entire process contrasts with a moral guidance consult, whose espoused goal is to make a recommendation or at least suggest a range of acceptable courses—essentially a nonbinding arbitration, as noted. It can be a valuable service, yet very different from mediation. Likewise, the information dynamics are very different between mediation and a guidance consult. If the situation features conflict, then a truthful disclosure, up front, that the consultant plans to make recommendations—that he or she may favor one/some viewpoint(s) over others—effectively encourages parties to frame their information for persuasive purposes, to win the consultant over. Parties will essentially be *lobbying* more than earnestly disclosing.

C. *Self-determination: "I am not here to tell anyone what to do"*

From AAA/ABA/ACR Model Standard I-A: "A mediator shall conduct a mediation based on the principle of party self-determination. Self-determination is the act of coming to a voluntary, uncoerced decision in which each party makes free and informed choices as to process and outcome..."

Mediators who make decisions for the parties are not functioning as mediators at all, but as arbitrators. In a more limited fashion, if a mediator unilaterally circumscribes the parties' options – as in, "you may freely choose among A, B, and C, but you may not choose D" – then s/he is mixing arbitration into mediation. Per mediation standards: "A mediator shall not conduct a dispute resolution procedure other than mediation but label it mediation . . ."¹²

Here, too, the core principle is rooted in ethics, not just the definition or optimal strategies of mediation. Once the mediator describes what s/he is offering and invites parties to accept, a retroactive interference with parties'

¹¹ Even where mediation is court-ordered, as where a judge requires parties to try mediation before they proceed to trial, the process is still fundamentally voluntary. Once parties show up for mediation, they have fulfilled their obligation. The court cannot require them to settle, hence the mediator's best strategy is to describe what s/he is offering, invite parties to give the process a try, and turn the court-ordered mediation into a voluntary one.

¹² MODEL STANDARDS, *supra* note 9, Standard VI.A.6.; see also Armand H. Matheny Antommaria, *Alternative Dispute Resolution and Pediatric Clinical Ethics Consultation: Why the Limits of Ethical Expertise and the Indeterminacy of the Best Interests Standard Favor Mediation*, 23 OHIO ST. J. ON DISP. RESOL. 17, 45–46 (2007).

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options can amount to a breach of promise, a failure of truth in advertising.¹³

An important contextual difference between lawsuit mediation and mediation in the clinical setting highlights the importance of self-determination. Mediated lawsuit settlements ordinarily yield a binding contract, enforceable in court. Parties who later regret their decision have limited recourse. In contrast, clinical agreements typically have no enforceability other than the parties' actual agreement, their genuine willingness to affirm and implement their plan.¹⁴ Hence, authentic agreement should not be confused with *bullied acquiescence* – the reluctant "yes" that might eventually come when someone simply doesn't want to discuss a matter further. Such agreements can fall apart quickly, as where a family "agrees" to a DNR order under pressure, only to rescind it hours later because they did not actually endorse the idea in the first place. Hence, this Article emphasizes the importance of a *durable* resolution, and what is necessary to reach that end.

D. Styles of Mediation

Within these basic principles, mediation can proceed in diverse ways, depending on the mediator's style and the parties' inclinations. Some approaches focus on parties' relationships. *Transformative* mediation, for instance, aims less to settle disputes, and more "to help people gain a deeper understanding of themselves and those they interact with."¹⁵ *Narrative* mediation likewise focuses less on solving a concrete problem, than on helping parties construct their stories; if successful, "participants walk away with a new story about their interaction with one another."¹⁶

When a dispute needs clear resolution, mediators commonly use either (or a mix) of two other styles: facilitative or evaluative. A *facilitative* mediator uses skilled questioning and listening to elicit parties' underlying concerns and help them craft their own resolution. S/he may invite them to explore potential consequences of various options but, under the assumption that they know their own situation better than the mediator, does not pointedly evaluate those

¹³ This is not to say that a mediator must somehow ensure that parties can choose literally anything they want regardless of, e.g., laws to the contrary. Externally authoritative constraints will be discussed below, under "Reality Checks."

¹⁴ Agreements can fall apart for other reasons, of course, e.g., as a patient's condition unexpectedly changes.

¹⁵ ELLEN WALDMAN, MEDIATION ETHICS: CASES AND COMMENTARIES, 22 (2011). See also Robert Arnold et al., *A Commentary on Caplan and Bergman: Ethics Mediation—Questions for the Future*. 18 J. CLINICAL ETHICS 350, 352 (2007). See generally ROBERT A. BARUCH BUSH & JOSEPH P. FOLGER, THE PROMISE OF MEDIATION: THE TRANSFORMATIVE APPROACH TO CONFLICT. (rev. ed. 2005).

¹⁶ WALDMAN, *supra* note 15, at 23. See also Arnold et al., *supra* note 15.

options.¹⁷

In contrast, *evaluative* mediation sees parties as looking for advice in addition to process.¹⁸ Plaintiffs in personal injury suits, e.g., may have unrealistic expectations about their case's monetary value. Attorneys on both sides often want a trial-experienced mediator to offer an honest appraisal of the case's value and what may happen in court if the dispute doesn't settle. Even then, an evaluative mediator must refrain from telling parties what to do.¹⁹

IV. BIOETHICS MEDIATION: VARIATIONS ON THE CONCEPT, AND DEVIATIONS FROM CORE PRINCIPLES

Mediation entered healthcare's clinical setting in the early 1990s. A landmark achievement, it should be gratefully acknowledged by all who do bioethics in healthcare. "Bioethics Mediation" (BEM), as the most prominent approach has been called, is the most widely taught and referenced.²⁰ As discussed just below, "Clinical Ethics Mediation"²¹ embraces many of BEM's basic tenets, while "Ethics Facilitation"²² provides a somewhat downsized version of BEM that nevertheless shares key features. Each has been described directly,²³ and key tenets of BEM have often been presumed or incorporated by other scholars.²⁴

¹⁷ *Id.*

¹⁸ *Id.* at 24.

¹⁹ See, e.g., Jacqueline M. Nolan-Haley, *Lawyers, Non-Lawyers and Mediation: Rethinking the Professional Monopoly from a Problem-Solving Perspective*, 7 HARV. NEGOT. L. REV. 235, 271 (2002).

²⁰ See, e.g., DUBLER & LIEBMAN, *supra* note 2; Nancy Neveloff Dubler, *A Principled Resolution: The Fulcrum for Bioethics Mediation*, 74 L. & CONTEMP. PROBS. 177 (2011).

²¹ See EDWARD J. BERGMAN & AUTUMN FIESTER, *The Future of Clinical Ethics Education: Value Pluralism, Communication, and Mediation*, in *THE FUTURE OF BIOETHICS: INTERNATIONAL DIALOGUES* 703, 707–08 (Akira Akabayashi ed., 2014). See also Autumn Fiest, *Contentious Conversations: Using Mediation Techniques in Difficult Clinical Ethics Consultations*, 26 J. CLINICAL ETHICS 324 (2015).

²² AM. SOC'Y FOR BIOETHICS HUMAN., *CORE COMPETENCIES FOR HEALTHCARE ETHICS CONSULTATION* (2d ed. 2011).

²³ *Id.*; BERGMAN & FIESTER, *supra* note 21, at 707–708; DUBLER & LIEBMAN, *supra* note 2; NANCY NEVELOFF DUBLER & LEONARD J. MARCUS, *MEDIATING BIOETHICAL DISPUTES: A PRACTICAL GUIDE* (1994); Dubler, *supra* note 20, at 177–200; Fiest, *supra* note 21, at 326; Diane E. Hoffman, *Mediating Life and Death Decisions*, 36 ARIZ. L. REV. 821, 821–877 (1994).

²⁴ LEONARD J. MARCUS ET AL., *RENEGOTIATING HEALTH CARE: RESOLVING CONFLICT TO BUILD COLLABORATION* (2011); Yvonne J. Craig, *Patient Decision-Making: Medical*

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BEM matches traditional mediation in many ways, but adds significant deviations. Per Dubler and Liebman, BEM strives not for whatever the parties want, simpliciter, but rather for a "principled resolution,"²⁵ namely, a plan that, although the product of a mediated conversation among the parties, nevertheless also "falls within clearly accepted ethical principles, legal stipulations, and moral rules defined by ethical discourse, legislatures, and courts"²⁶ A principled resolution reflects the strength of a mediative process that incorporates legal norms and ethical conventions and intuitions and uses both of these as support for forging a consensus in a crisis.²⁷ In other words, the mediator helps the parties to negotiate, but will directly prevent them from stepping outside ethical or legal norms.

The American Society for Bioethics and Humanities offers a somewhat parallel approach: "Ethics Facilitation" (EF). Although the ethics facilitator does not claim to be a mediator, this approach expressly adopts BEM's concept of a principled resolution that emerges from facilitated conversation.²⁸ The ethics consultant generally promotes the parties' own decision-making, yet must not embrace a "pure consensus" or "anything goes" approach that could run afoul of "widely accepted ethical and legal norms and standards."²⁹ Instead, an EF consultant will "(1) identify[] and analyz[e] the nature of the value uncertainty, and (2) facilitat[e] the building of a principled

Ethics and Mediation, 22 J. MED. ETHICS 164, 164–167 (1996); Fiester, *supra* note 21, at 326; Kevin Gibson, *Mediation in the Medical Field*, 29(5) HASTINGS CTR. REP. 6, 6–13 (1999); Joan McIver Gibson, *Mediation for Ethics Committees: A Promising Process*, 18(4) GENERATIONS 58, 58–60 (1994); Amy Moorkamp, *Don't Pull the Plug on Bioethics Mediation: The Use of Mediation in Health Care Settings and End of Life Situations*, (1) J. DISP. RESOL. 219, 219–235 (2017); Robert D. Orr, *Methods of Conflict Resolution at the Bedside*, 1(4) AJOB 45, 46 (2001); Bethany Spielman, *Bargaining About Futility*, 23 J. L. MED. AND ETHICS 136, 136–142 (1995); Waldman, *supra* note 5, at 449–471; Ellen Waldman, *Mediating Difference: Normative Conflict as Opportunity*, 3(2) AJOB 25, 25–27 (2003); Mary Beth West, Joan McIver Gibson, *Facilitating Medical Ethics Case Review: What Ethics Committees Can Learn from Mediation and Facilitation Techniques*, 1(1) CAMBRIDGE Q. OF HEALTHCARE ETHICS 63, 63–74 (1992); Robert J. Wagener, *Introducing Mediation to Hospital Ethics*, CAL. LAWYER, Dec. 1992, at 69.

²⁵ DUBLER & LIEBMAN, *supra* note 2, at 12, 14.

²⁶ *Id.* at 14.

²⁷ *Id.* at 14. "A principled resolution is a 'consensus that identifies a plan that falls within clearly accepted ethical principles, legal stipulations, and moral rules defined by ethical discourse, legislatures, and courts, and that facilitates a clear plan for future intervention.'" Dubler, *supra* note 20, at 178.

²⁸ To be precise, Ethics Facilitation does not purport to be mediation as such. Nevertheless, its direct adoption of BEM's "principled resolution" concept subjects it to the same basic concerns.

²⁹ AM. SOC'Y FOR BIOETHICS HUMAN., *supra* note 22, at 7.

ethical resolution.³⁰ A consultant can permissibly share his or her ethics expertise and even make recommendations, particularly if a proposed course of action appears to be unethical.³¹ To the extent that EF mirrors BEM, we will see that it suffers the latter's weaknesses.³²

Fiester and Bergman, describing "Clinical Ethics Mediation" (CEM), agree with BEM and with EF that "anything goes" mediations cannot be permitted. Indeed, the very idea of *carte blanche* mediation is essentially a straw man, they suggest, since "resolutions that are legally untenable or morally unsupportable could be fashioned by the dissolute as long as the outcome is expedient and attractive to all of the involved parties. . . . In fact, the gold standard for a mediated outcome is articulated by Dubler and Liebman as 'a plan that falls within clearly accepted ethical principles, legal stipulations, and moral rules."³³ "Clinical ethics mediators are constrained [by] . . . 'principled resolution.' . . . Clinical ethics mediators have the responsibility of understanding, in addition to knowing the techniques of conflict resolution,

³⁰ *Id.*

³¹ *Id.* at 8. At the same time, they should refrain from recommending just one option if more than one is ethically acceptable. *Id.* at 8–9.

³² By some definitions, ASBH's "ethics facilitation" approach should not actually be called "facilitation." Someone who facilitates a meeting, for instance, is said to do so in a setting where the group faces a task, but not a conflict. Facilitation, that is, is a pre-conflict process. Janice M. Fleischer and Zena D. Zumeta, *Preventing Conflict Through Facilitation: A Comparison of Mediation and Facilitation*, 4 DISP. RESOL. MAG. (1997–1998), <http://collaborateatwork.com/resources/facilitation.php>. The facilitator's job is to keep the conversation on track, ensure diverse perspectives are heard, and ensuring that decisions and questions are properly recorded and pursued following the meeting. Per the Cambridge Dictionary, "facilitation" is "the act of helping other people to deal with a process or reach an agreement or solution without getting directly involved in the process, discussion, etc. yourself." *Facilitation*, CAMBRIDGE BUSINESS ENGLISH DICTIONARY, <https://dictionary.cambridge.org/us/dictionary/english/facilitation> (last visited Oct. 2, 2019); "A facilitator is a guide to help people move through a process together, not the seat of wisdom and knowledge. That means a facilitator isn't there to give opinions, but to draw out opinions and ideas of the group members...Facilitation focuses on how people participate in the process of learning or planning, not just on what gets achieved...A facilitator is neutral and never takes sides." Community Tool Box, Ch. 16, Sec. 2: Developing Facilitation Skills, <https://ctb.ku.edu/en/table-of-contents/leadership/group-facilitation/facilitation-skills/main>. *See also*, e.g., Mind Tools Content Team. The Role of a Facilitator: Guiding an Event Through to a Successful Conclusion, <https://www.mindtools.com/pages/article/RoleofAFacilitator.htm> (last visited September 13, 2019).

³³ Fiester, *supra* note 21, at 326. Fiester continues: "That said, it is an easy temptation for CECs to mistake their own preferred ethical principle in a case as the universal standard of 'clearly accepted ethical principles.'" *Id.* *See also* BERGMAN & FIESTER, *supra* note 21, at 703–11.

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what constitutes a solution that runs afoul of the law, hospital policy, or the ethical scaffolding in the community that supports them."³⁴

Fiester and Bergman do offer caveats. Fiester strongly cautions against mediators inserting their own personal ethical values into the process, or recommending particular solutions where more than one option is acceptable.³⁵ And both of them note that clinical ethics mediation often takes place in a setting of "moral aporia," characterized by "perplexity, impasse, deadlock, or stalemate 'from which there is seemingly no way out . . .'"³⁶ Aporia, obviously, would not involve correcting morally wayward beliefs, since by definition it is a situation with no clearly right or wrong answer. That said, like BEM and EF, CEM will expressly enforce boundaries of ethics, morals, and law.

As a somewhat speculative historical observation, it may be that as bioethics consultants recognized how frequently conflict figured into ethics consults, and as the potential role of mediation became apparent in the early 1990s, it may have been assumed that a consultant could and should provide mediation services even while continuing to serve as a traditional moral-guidance consultant. However, combining mediation with moral guidance proves problematic. As discussed now, BEM violates all three of the core mediation values: confidentiality, neutrality, self-determination. Although CEM and EF do not extensively discuss confidentiality or self-determination, their approach to neutrality matches BEM's, hence they share its flaws.

A. Confidentiality

Bioethics Mediation offers both a promise and a limitation regarding confidentiality. The promise is that parties' statements in mediation will not be used against them in any ensuing legal action.³⁷ "Confidentiality allows the parties to speak freely, without fear that what they say during the mediation

³⁴ *Id.* at 707.

³⁵ Autumn Fiester, *Mediation and Recommendations*, 13(2) AM. J. BIOETHICS 23–24 (2013).

³⁶ Edward J. Bergman, *Surmounting Elusive Barriers: The Case for Bioethics Mediation*, 24(1) J. CLINICAL ETHICS 11, 13 (2013). See also Autumn Fiester, *Mediation and Moral Aporia*, 18(4) J. CLINICAL ETHICS 355, 355–56 (2007) (recommending against vote-like processes to "resolve" such aporia); Autumn M. Fiester, *Ill-Placed Democracy: Ethics Consultations and the Moral Status of Voting*, 22(4) J. CLINICAL ETHICS 2011 363, 363–72 (2011) (recommending that cases in which *aporia* precludes any clear resolution are best resolved through mediation).

³⁷ Don F. Reynolds, *Consultecomics: Ethics Committee Case Consultation as Mediation*, 10(4) BIOETHICS FORUM 54, 55, 58 (1994); DUBLER & LIEBMAN, *supra* note 2, at 12, 56.

will have repercussions in a subsequent proceeding.³⁸ Per Bergman: "[t]he confidentiality of mediation communications is frequently protected by statute. Many states have adopted the Uniform Mediation Act, which privileges mediation communications, disallowing their use in subsequent court proceedings, with rare exceptions."³⁹

That said, BEM stipulates that confidentiality does not encompass information relevant to patient care. "Good medical care requires that all providers share information about the patient's condition and care with each other across disciplines and between shifts."⁴⁰ "[N]ew information significant to the patient's condition that comes out in mediation, will be recorded in the patient's chart."⁴¹ Hence confidentiality is not guaranteed ". . . except for personal secrets unrelated to the care plan"⁴² Indeed, rather little confidentiality is promised. If mediation leads to agreement, the bioethics mediator "is responsible for entering in the patient's chart not only an account of any agreed-upon recommended plan regarding care, but also an explanation of the process followed and principles relied upon in reaching that agreement."⁴³ Depending on how it is done, this retrospective play-by-play could mean very little is left of the initial promise of confidentiality.

This approach is problematic on two counts. First, a flat claim that Bioethics Mediation presumptively enjoys evidentiary privilege is simply incorrect. Although states' statutes and rules governing mediation vary, evidentiary privilege generally applies in the context of an active lawsuit. Many states, for instance, base their mediation privilege on Federal Rule of Evidence 408: "[W]hether in the present litigation or related litigation, . . . [e]vidence of conduct or statements made in compromise negotiations is . . . not admissible."⁴⁴ A few states do expressly protect mediation confidentiality outside the setting of an active lawsuit, albeit typically with limitations. Mediation privilege in Florida can be honored outside the litigation context, for instance, but only if the mediator is certified by that state's Supreme

³⁸ DUBLER & LIEBMAN, *supra* note 2, at 12.

³⁹ Bergman, *supra* note 36, at 12 (citing N.J. Stat. Ann. § 2A:23C-1. (West 2019)).

⁴⁰ DUBLER & LIEBMAN, *supra* note 2, at 25; Reynolds, *supra* note 37, at 55.

⁴¹ DUBLER & LIEBMAN, *supra* note 2, at 25.

⁴² *Id.* at 26.

⁴³ *Id.* at 30.

⁴⁴ TENN. R. EVID. 408. *Compare id.*, with FED. R. EVID. 408 (providing that parties may not admit evidence of "conduct or a statement made during compromise negotiations about the claim" to "prove or disprove the validity or amount of a disputed claim or to impeach by a prior inconsistent statement or a contradiction.").

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Court.⁴⁵ Although this is not the forum for extended discussion, suffice it to say the bare fact that people in a healthcare argument call their conversation a mediation and assert that it is confidential, does not necessarily shield that conversation from discovery if a lawsuit is subsequently filed.⁴⁶ Additionally, if a mediator provides a detailed record of the mediation process, including its participants, issues, options, conclusions and reasons for those conclusions,⁴⁷ then any shred of privacy for the mediation will largely have been waived, given that medical records are discoverable in litigation.

Second, BEM fails protect privacy where it is most needed. To begin with, for mediations in the clinical setting the value of confidentiality only minimally concerns the usually long-shot (in these cases) possibility of discovery in litigation. Rather, what most matters in the clinical setting is typically the concern that sensitive information not be disclosed to others in important relationships—"Never mind lawsuits. It's my mother-in-law [my boss, my co-worker, that doctor, . . . my spouse]⁴⁸ who mustn't know this."

In this vein, BEM burdens trust greatly by specifically carving out patient information as a large exception to confidentiality. If the mediator is honest enough to say, up front, that "anything medically relevant will be passed along to providers," the leery patient or family will likely withhold sensitive information. Alternatively, if that mediator does not provide such a warning, but then passes along patient-related information, trust will likely be seriously damaged when the patient/family learn that the promise of confidentiality had this large, unrevealed exception. And mediation's ethical protection for confidentiality will have been breached.

Admittedly, providers need to know patients' information. But if a patient or family have chosen not to disclose something, they have reasons. The information may be embarrassing, or perhaps they dislike their providers. Those reasons don't disappear simply because a mediation has begun. Far

⁴⁵ Fla. Stat. § 44.402(c) (2019): "Facilitated by a mediator certified by the Supreme Court, unless the mediation parties expressly agree not to be bound by §§ 44.40–44.406." See also, Md. Code § 3-1801.

⁴⁶ See Jay M. Zitter, Annotation, *Construction and Application of State Mediation Privilege*, 32 A.L.R. 6th 285 (2008); see also Judy Shopp, *Mediation: Confidentiality and Privilege*, 81 PA. B. ASS'N Q. 101 (2010), <https://www.ogc.pa.gov/Services%20to%20Agencies/Mediation%20Procedures/Documents/PABAR%20Shopp%20New%20Cx%20Article.pdf>.

⁴⁷ See DUBLER & LIEBMAN, *supra* note 2, at 95–104 (introducing "bioethics mediation chart note" as an example of a detailed record of the mediation process).

⁴⁸ Additionally, mediators must protect information from others in the institution who might want to learn it, including risk managers, in-house counsels and the like. It is for this reason that organizational ombuds offices, including those established in medical centers, are structured to ensure such confidentiality. See CHARLES L. HOWARD, THE ORGANIZATIONAL OMBUDSMAN: ORIGINS, ROLES, AND OPERATIONS 190–91 (2010).

better, a mediator should be someone in whom patient/family, and providers too, are willing to confide. If the mediator believes it would be helpful to share some bit of information with others, s/he can explain why and ask for permission, perhaps offering ideas on how that information might be framed so as to minimize whatever problem is feared. But if that person does not agree, the information must remain private – thereby solidifying trust for the mediator and potentially opening the door to sharing, later on.

The bottom line is very practical. Confidentiality promotes the trust that is prerequisite for unearthing the back-stories that are critical to learning what, really, is at issue. If those underlying issues are not revealed and addressed, any putative "resolution" is likely to fall apart—often quickly. And the bottom line is also ethics: BEM's willingness to sacrifice patients' privacy directly violates a longstanding principle of mediation ethics, while asserting a largely illusory "protection" against discovery in litigation.

B. *Neutrality*

While attempting to help people in conflict to identify their interests and reach common ground, BEM, EF and CEM all expect the mediator to ensure that any resolution is "principled"—that it will honor "clearly accepted ethical principles, legal stipulations, and moral rules."⁴⁹ A proposal that would violate any of these—even one embraced by all the parties—will be expressly argued against or outright preempted.⁵⁰ Thus, if options A, B, and C are deemed ethically acceptable but D is not, then a mediator adhering to BEM, EF or CEM may not allow D on the table, even while helping people freely to

⁴⁹ DUBLER & LIEBMAN, *supra* note 2. See also AM. SOC'Y FOR BIOETHICS HUMAN., *supra* note 22, at 7–8 (The two core features of the ethics facilitation approach include "(1) identifying and analyzing the nature of the value uncertainty, and (2) facilitating the building of a principled ethical resolution. . . . [including to] help to identify a range of ethically acceptable options within the context and provide an ethically appropriate rationale for each option."); BERGMAN & FESTER, *supra* note 21, at 707 ("Clinical ethics mediators are constrained in a parallel way. This is what advocates of clinical mediation refer to as 'principled resolution' (Dubler and Liebman 2011). Clinical ethics mediators have the responsibility of understanding, in addition to knowing the techniques of conflict resolution, what constitutes a solution that runs afoul of the law, hospital policy, or the ethical scaffolding in the community that supports them.") (emphasis added); Fester, *supra* note 21, at 326 ("[T]he gold standard for a mediated outcome is articulated by Dubler and Liebman as 'a plan that falls within clearly accepted ethical principles, legal stipulations, and moral rules.' . . . Within the parameters of law, hospital policy, broad societal consensus, and '*accepted ethics principles*,' bioethics mediators need to be neutral about the resolution decided by the parties") (emphasis added).

⁵⁰ See Waldman, *supra* note 5, at 455–57; see also AM. SOC'Y FOR BIOETHICS HUMAN., *supra* note 22, at 8; DUBLER & LIEBMAN, *supra* note 2, at 23–24.

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negotiate among A, B and C.⁵¹ Similarly, a proposal's medical or legal inadequacies could also trigger rejection by a mediator or facilitator offering BEM, CEM or EF.⁵²

Critical analysis of this approach requires an important distinction. Mediations do indeed operate within constraints. However, we must distinguish between, on one hand, *externally authoritative restrictions* such as laws, institutional policies or empirical realities and, on the other, the ethical norms or moral rules by which these mediators further constrain parties' options.

Regarding the former: mediation, whether in the clinical setting or anywhere else, takes place in a world of concrete realities that neither mediators nor parties can change – empirical facts, legal systems, institutional policies. Examples: hospital policies typically restrict medical practice within their walls to credentialed physicians; empirically, if a leg has been amputated, it is gone; legally, statutes, administrative rules and case law define scope of practice for various health professions. Such realities cannot plausibly be ignored in mediation if the parties are to reach a durable resolution. Where externally authoritative realities thus limit parties' options, the mediator can rightly introduce them. The challenge then is not whether they can be included, but how. This is discussed below, under "reality checks."

⁵¹ Of interest, Bergman at times seems undecided about whether he actually adheres to the concept of "principled ethical resolution": Calling claims to superior moral knowledge "dubious," he notes that:

[s]uperior access to ethically correct choices would render a bioethics mediator incapable of neutrality as to outcomes and limit the mediator to neutrality regarding the parties. This limited definition of neutrality will offend mediation purists as violative of the premise that advocacy for, or against, outcomes that parties reach consensually, is inherently partial.

Bergman, *supra* note 36, at 16. Of note, this passage is descriptive rather than prescriptive, and Bergman/Fiester's subsequent writings make it clear they join the camp of "principled resolution."

⁵² BEM goes beyond moral acceptability, to "ensure[] that resolutions fall within medical best-practice guidelines." DUBLER & LIEBMAN, *supra* note 2, at 23. The authors go on to assert that the bioethics mediator "must be sure that any agreement is in the best interest of the patient, that it comports with the medical ethical norm of 'do no harm,' and that it meets the state's legal requirements. Furthermore, it is not sufficient for the mediator to arrive at a solution that all accept if that solution compromises the best widely accepted medical care plan and leaves the patient less well off. Thus the boundaries of a principled resolution are legal, ethical, and medical." *Id.* at 24.

In contrast, a mediator's claim to possess—and impose—*morally* authoritative truth introduces a very different element. Note first, our most important moral judgments are generally also embodied in law, rendering them externally authoritative. Killing a human being is not just morally wrong. Barring unusual circumstances, it is also legally prohibited. As noted, mediators may rightly bring legal constraints into the discussion.

Beyond that, however, moral matters quickly become cloudy. This is not the place to discuss ethical realism versus relativism, but a practical point seems obvious. *If everyone at the table accepts a particular moral norm, then the mediator need not "enforce" it, because everyone already accepts it. On the other hand, if some at the table reject a particular principle, then obviously it is not "clearly accepted."*⁵³ And one wonders on what basis the mediator could justify imposing it anyway on resistant parties.

As recognized by other commentators, we need not look far to find examples of "clearly accepted" norms that are actually quite controversial. First example, Dubler asserts that "[d]eath may be preferable to extending the process of dying in children and incompetent patients."⁵⁴ By no means is this principle is universally accepted. Some religions' vitalist philosophy asserts that all life is infinitely precious regardless of quality, and that prolonging it even briefly is of infinite value.⁵⁵ To declare vitalists morally incorrect because they deny "clearly accepted" norms fallaciously begs the question. "Accepted" by whom, one must ask.

A second example: the mediator "must be sure that any agreement is in the best interest of the patient"⁵⁶ and "neither financial strain on the hospital nor social stress on the family are appropriate grounds for treatment withdrawal."⁵⁷ A counterexample highlights the problem: in one recent Tennessee case, the child of an Amish family needed ECMO⁵⁸ to survive. The family declined, not because they did not want their child to live, but because

⁵³ On the medical side, not all claims about a patient's diagnosis, prognosis, and treatment options are incontrovertible. Very good physicians can disagree, and medical "best-practices" change continually. The patient may in fact be correct and, more to the point, the mediator who "educates" patients about the medical situation may quickly be deemed the physicians' apologist or teammate. Better that the mediator explores patients' reasons for doubt or mistrust.

⁵⁴ Dubler, *supra* note 20, at 181.

⁵⁵ Thalia Arawi & Lama Charafeddine, *When a Physician and a Clinical Ethicist Collaborate for Better Patient care*, 18 DEVELOPING WORLD BIOETH. 198, 201 (2018), <https://onlinelibrary.wiley.com/doi/abs/10.1111/dewb.12188>.

⁵⁶ DUBLER & LIEBMAN, *supra* note 2, at 24.

⁵⁷ Waldman, *supra* note 5, at 457; see also DUBLER & LIEBMAN, *supra* note 2, at 23.

⁵⁸ In ECMO (extra-corporeal membrane oxygenation), "gas exchange occurs by means of an extracorporeal membrane perfused with venous blood." C. Corey Hardin & Kathryn Hibbert, *ECMO for Severe ARDS*, 378 NEW ENG. J. MED. 2032, 2033 (2018).

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the expense would financially decimate their community. The community paid for medical care directly out of their collective resources and could not afford to place this one person's wellbeing above that of all others'. Patients are not alone in the moral universe, and one is hard-pressed to defend a norm holding that, solely because one person is at the moment labeled "patient," his interests must always trump everyone else's.

A third supposedly accepted principle: "competent adult patients should be informed of their diagnosis unless it is certain that immediate and severe harm will result."⁵⁹ While broadly shared in the West, some other cultures believe that to speak aloud of a fatal illness is to make it happen, or to cause shame.⁶⁰ Challenging cultural beliefs that are based on non-(dis)provable metaphysical commitments may be suitable for a guidance-type ethics consult, but cannot claim universal acceptance.⁶¹

The problems go deeper than contestable claims to superior moral knowledge.⁶² In effect the mediator who imposes moral norms has crossed over from mediation, whose very definition emphasizes impartiality, into a combination of mediation and arbitration. In arbitration, a third party hears the relevant information and makes decisions. In BEM, it is said that "[s]ometimes in bioethics mediation the mediator needs to step out of the role of mediator

⁵⁹ JONATHAN D. MORENO, DECIDING TOGETHER: BIOETHICS AND MORAL CONSENSUS 19 (1995).

⁶⁰ David M. Adams, *Ethics Consultation and 'Facilitated' Consensus*, 20 J. CLINICAL ETHICS 44, 51 (2009); see also Lucette Lagnado, *In some cultures, cancer stirs shame*, WALL ST. J. (Oct. 4, 2008), <https://www.wsj.com/articles/SB122304682088802359>.

⁶¹ Bergman and Fiester, for instance, assert that "in the United States, competent patients must give their informed consent to any invasive procedure, or they must waive their right to it. A mediator, consequently, cannot facilitate a solution that denies a competent patient access to this right or waiver." BERGMAN & FIESTER, *supra* note 21, at 707. If introduced as a moral rather than legal constraint, the assertion is thinly-based cultural relativism. As noted by Asai and Kadooka, Confucian value systems "place a lower significance on an individual's or patient's right to self-determination than collective decision-making. . . . [T]he principle of patient autonomy may be of less significance in certain Asian cultures with ties to Confucian traditions, which place higher value on family cohesion, ancestor worship, and filial piety." Atsushi Asai & Yasuhiro Kadooka, *Commentary: Barriers to Clinical Ethics Mediation in Contemporary Japan*, in THE FUTURE OF BIOETHICS: INTERNATIONAL DIALOGUES 712, 714 (Akira Akabayashi ed., 2014).

⁶² See Bergman, *supra* note 36, at 16; see also Giles R. Scofield, *Ethics Consultation: The Least Dangerous Profession?*, 2 CAMBRIDGE Q. HEALTHCARE ETHICS 417, 421 (1993); Fiester, *supra* note 36; David J. Casarett et al., *Experts in Ethics? The Authority of the Clinical Ethicist*, HASTINGS CTR. REP., Nov.–Dec. 1998, at 6; H. Tristram Engelhardt, JR., *Consensus Formation: The Creation of an Ideology*, 11 CAMBRIDGE Q. HEALTHCARE ETHICS 7 (2002); Griffin Trotter, *Bioethics and Healthcare Reform: A Whig Response to Weak Consensus*, 11 CAMBRIDGE Q. HEALTHCARE ETHICS 37, 39 (2002).

and into the role of consultant, most often when the process is leading to an ethically unsupportable outcome.⁶³ The mediator thus is said to "always wear two hats" because s/he unilaterally removes certain options from the table even while permitting parties to choose among the remaining options.⁶⁴

This is arbitrating-while-mediating—not merely describing popular norms to parties, but actively constraining their decisions.⁶⁵ It contravenes ABA/AAA/ACR ethical standards: "A mediator shall not conduct a dispute resolution procedure other than mediation but label it mediation . . ."⁶⁶

By violating mediation's core principle of neutrality, a mediator's assertions of superior moral authority can damage a mediation. To prohibit an "unacceptable" option is to take sides on that issue. Once the mediator takes sides, trust can quickly erode.⁶⁷ Parties' willingness to provide sensitive information predictably diminishes, their disclosures quickly becoming a form of lobbying-to-persuade rather than confiding what is most important. Their interests are now best promoted by either reinforcing the mediator's perspective if it favors their side, or by trying to change the mediator's mind. Neutrality dissipates and the mediator becomes just another pair of fists in the fight. Hence a major reason to avoid taking sides is very practical: it greatly diminishes the likelihood of a durable resolution. Instead of inviting mediators to abdicate neutrality, parties who are puzzled by a question, whether moral, medical or otherwise, can seek external consultation from a bioethicist, clergy, physician or the like.

Instead of breaching neutrality, a mediator who deems parties' preferred course morally unacceptable has a well-recognized response:

⁶³ DUBLER & LIEBMAN, *supra* note 2, at 15.

⁶⁴ *Id.* at 16. Such arbitrating-while-mediating, mixing a guidance-type consult with mediation, can occur either sporadically or pervasively. The authors, for instance, describe one mediation in which "the roles of mediator, helping the parties to identify options for solution and choose among them, and consultant, identifying the right of the patient to choose death and working clearly toward that goal, were intertwined during all stages of the mediation." *Id.* at 139. Somewhat oddly, Dubler and Liebman actively reject *med-arb*, "a process in which the mediator changes roles and becomes the decision maker when the parties are unable to reach agreement." *Id.* at 15–16. Note also, such a dual role violates a standard of mediation: "Mixing the role of a mediator and the role of another profession is problematic . . ." MODEL STANDARDS, *supra* note 9, Standard VI.A.5.

⁶⁵ See Antommaria, *supra* note 12, at 45.

⁶⁶ MODEL STANDARDS, *supra* note 9, Standard VI.A.6.; see also Antommaria, *supra* note 12.

⁶⁷ As Leahy notes, a Bioethics Mediator's willingness to maneuver parties toward the "correct" choice, or at least away from an "incorrect" choice, quickly becomes manipulation and overreach. Christopher Leahy, *The Perils of Being Persuasive.*, DISP. RESOL. MAG., Summer 2018, at 33, 35.

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withdraw.⁶⁸ An example from a recent civil mediation⁶⁹ will highlight. The adult son of a deceased man had sued two of the deceased's "nonmarital" children, demanding return of Father's property that was in defendants' possession. Quickly, it became evident that Father's children numbered twelve, not just these three. Given the law of intestate succession in that state, all twelve had equal rights to any property. The mediator's response: "As a mediator I cannot help you divide these items just among yourselves, because the other heirs also have a rightful place at the table. However, I would be happy to help you negotiate exchanges in which you convey your 1/12th interest in a given item in exchange for another child's 1/12th interest in some other item; or perhaps we could discuss how to reach out to your siblings; or you may have other ideas on what to do next. You are free to do as you wish outside the mediation context, but as a mediator I must draw this limit on my own participation." The mediator did not forbid or prevent the three children from exchanging Father's property just among themselves, nor did she reach out to contact other siblings, because a mediator is not an enforcer. If these three divide property among themselves, the other siblings could challenge it. But that is not the mediator's business. Rather, the mediator must withdraw from the original question posed for the mediation and explore alternatives that would be permissible if the parties wish to continue in mediation. This same approach—"I cannot be part of this, for the following reason(s)"—should likewise prevail where the mediator deems an option ethically unacceptable.⁷⁰

C. *Self-determination*

Bioethics Mediation additionally abridges self-determination by engaging in post-agreement enforcement. "Once a compromise is reached, the mediator's job is to be its advocate to ensure it is implemented."⁷¹ The

⁶⁸ MODEL STANDARDS, *supra* note 9, Standard VI.A.9. See also Ellen Waldman, *A Theory of Mediators' Ethics: Foundations, Rationale, and Application*. DISP. RESOL. MAG., Summer 2017, at 19, 20 (reviewing Omer Shapira, *A Theory of Mediators' Ethics: Foundations, Rationale, and Application*).

⁶⁹ This dispute, adapted for confidentiality, was mediated by the author.

⁷⁰ Standard exceptions, of course, apply to imminent threats of physical harm, child or elder abuse, or the like. As noted above, the mediator also is authorized to breach confidentiality in those specific instances. Fortunately, bona fide mediations do not ordinarily discuss, or take seriously, proposals to commit felonies. And as noted below, "reality checks" provide another means for addressing legally problematic proposals.

⁷¹ DUBLER & LIEBMAN, *supra* note 2, at 159. That is, when an agreement is forged, bioethics mediators are often involved in following up on implementation of the agreement. *Id.* at 29.

mediator's role can vary from case to case. He or she will not always be an enforcer in the fullest sense, but follow-up is said to be part of the job.⁷² Sometimes the mediator may only offer comfort and support to the family as a decision is carried out, or might suggest how hospital policy may need revision for future cases. In other instances, the mediator may actively ensure the plan is carried out as initially agreed.⁷³

Mediator-as-enforcer is problematic. If an agreement is later rejected by a party, a mediator who nevertheless tries to enforce it is effectively taking sides *post hoc* by supporting whichever party still favors the original agreement. The adverse consequences can be significant, depending on why the agreement has broken down. Sometimes a party has learned new information, or further reflected on considerations that were not clear in her thinking at the time. Or perhaps the person feels his "agreement" was the product, not of genuine approval, but of bullied acquiescence. This could happen, e.g., if the mediator has expressly excluded one or more options as morally unacceptable.

Moreover, if the mediator presses to implement the original agreement, parties can be ill-served. If the late-breaking information, developments or afterthoughts are important, that agreement may now be inadequate. Parties (including providers, not just patients and families) may have had difficulty articulating their concerns, and if they find little room for reconsideration, their resistance may increase. If someone no longer embraces a plan, he will often figure out a way to sabotage it—which, in turn, can predictably lead to further conflict. At this point the mediator is in danger of becoming an authority figure—just another pair of fists. And parties' willingness to consider another round of mediation may likewise diminish.

Far better is to recognize that if an agreement breaks down there are almost always important reasons. A mediator can be far more valuable by continuing to honor confidentiality, neutrality, and self-determination, and by being available as a trusted source who can help to bring forth new information or previously unarticulated concerns, helping parties re-negotiate toward an agreement that makes better sense.

⁷² In one example, a family was reported to have become actively hostile following a mediation. "In one more attempt at transparent mediative behavior, the mediators told the family that they would be required to alert the hospital administrators; once they did, they reported the fact to the family. They also informed the family that the director of security had been briefed on the matter." *Id.* at 160.

⁷³ *Id.* at 71–72.

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V. REALITY CHECKS

The willingness of BEM, CEM and EF to enforce ethical norms in mediation is sometimes justified by pointing to family law. After all, mediators for divorce or child custody are obliged to inform parties that their decisions must conform to certain norms and that when agreement is reached, a judge will approve, disapprove, or amend it.⁷⁴

However, a key difference between mediation for family litigation and BEM, CEM, and EF is that the norms being enforced in family law are statutes governing marriage and family – including marital property division, alimony, and child custody arrangements. As noted above, legal constraints are among the externally authoritative factors that, unlike purely ethical norms, can have an appropriate place in clinical-setting mediations.⁷⁵

More broadly, external constraints are features of the wider landscape within which parties must operate, and over which they have no direct control.⁷⁶ They include law, policy, and empirical facts, and they enter mediations as "reality checks." Unrecognized, such constraints can upend any agreement – although not by mediator intrusion. The mediator who introduces them thus is not personally taking sides, but rather is acknowledging a factor that could thwart the durability of even an enthusiastic agreement.

Even here, however, a mediator should proceed carefully. Often the question is not *whether* a reality check should enter the conversation, but *how* it should enter. The answer underlies all three of mediation's cornerstone principles, namely, the importance of building and preserving trust in the process and in the mediator. It is often not possible to resolve a conflict if we do not know, quite fully, what fuels it—the parties' underlying issues and unmet needs. And we cannot know what those are if parties are unwilling to disclose them. That willingness is best supported by confidentiality, neutrality, and self-determination.

As a result, mediators should avoid even the appearance of taking sides or directing the outcome – even where an external reality truly limits parties' options. If a reality check is needed, the mediator should generally seek

⁷⁴ Armand H. Matheny Antommaria, *Intensified Conflict Instead Of Closure: Clinical Ethics Consultants' Recommendations' Potential To Exacerbate Ethical Conflicts*, 15 AM. J. BIOETHICS 52, 52–53 (2015); Bethany Spielman, *Bargaining About Futility*, 23 J. L. MED. & ETHICS 136, 136 (1995); Craig, *supra* note 24, at 166.

⁷⁵ See *supra* Part III-B.

⁷⁶ Admittedly, a proffered medical fact, policy or bit of law may not always be entirely clear or sure. A diagnosis may be controversial, and laws and policies can be ambiguous. Where that is the case, the mediator should hesitate before deeming it a bona fide reality check. A better conversation will encompass those uncertainties and figure out how to manage them.

someone else to deliver it. This observation is intensely practical, not theoretical. Suppose, for instance, that a family wants their ventilator-dependent grandfather to be moved from the ICU to a regular floor while still on the vent. Assume such a move is simply impossible under the hospital's policies and physical layout. If the mediator directly says, "you can't do that," an emotionally drained family may (incorrectly) infer that s/he is siding with the hospital. Far better as a strategy for maintaining trust, the mediator could propose that the question be asked of an appropriate hospital administrator. As the administrator explains why vent-dependent patients cannot be supported on a regular floor, the mediator can then ask the family what they had hoped to achieve with such a move, and explore other ways of reaching those goals. Similarly, a question about law might be posed to in-house counsel or another appropriate source of objective information.

Logistics will play a role, of course, as it may not always be possible to bring the appropriate person into the conversation directly. Still, options can be found. Provider-patient/family conflicts often persist for extended periods. Hence, clinical mediation is commonly a series of conversations over time, with various combinations of people at various points—whatever works best under the circumstances. Accordingly, if administrators or in-house counsel are not available at one time, they may be available at another, or perhaps by phone.

As the mediator learns more about what is important to those in conflict, s/he may be in a good position to discern what sorts of resources may be needed to facilitate the conversation, and to arrange for them. If in-person conversation with the appropriate expertise is not possible, institutional policies may be available online, and questions of law can sometimes be addressed via appropriate statutes, case law, and lay-level explanatory documents. Where medical descriptions are disputed, outside second opinions can be helpful.

Overall, the goal for managing reality checks is a simple and fairly straightforward principle of mediation: use objective criteria whenever possible.⁷⁷ The mediator should avoid being, or being seen as, the source of "no you can't." If a reality check comes from an external authority—which it does, by definition—then that authority, not the mediator, should be its voice.

VI. MEDIATION IN HEALTHCARE'S CLINICAL SETTING

Those who introduced mediation into healthcare's clinical setting have provided an enormously valuable service, and mediation should enjoy an

⁷⁷ ROGER FISHER & WILLIAM URY, *GETTING TO YES: NEGOTIATING AGREEMENT WITHOUT GIVING IN* 81–84 (Bruce Patton ed., 2d ed. 1991).

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important place alongside other avenues for addressing conflict – coaching, negotiation, facilitation. Mediation has an extraordinary capacity to yield durable resolutions for even the most entrenched conflicts. Not always, of course, but far more often than one might imagine.

That said, mediation's core ethical principles must be honored: (1) confidentiality, including patient-specific information; (2) impartiality, not just as to parties but also as to outcomes—reality checks are legitimate, but need to be delivered skillfully and without abandoning neutrality; and (3) self-determination, including when parties wish to abandon an earlier agreement.

Mediation is but one vehicle for conflict resolution, and not typically the first tool to be drawn from the toolbox. It is quite highly specialized, requiring considerable training and regular practice, and not all bioethicists will opt to provide this particular service, even if they routinely employ conflict management skills. Bioethics consultants and others who provide conflict resolution services should freely use a broad variety of conflict management skills and strategies as they engage in triage, problem-solving, and even traditional moral-guidance consults. Indeed, it is not always clear from the outset whether a situation is best met with mediation, or via a traditional moral guidance consult. This is why the triage process discussed in Part I is typically the first task when an ethics consult is requested.

The bottom line for this Article, however, is that where mediation is used, it needs to be the real thing. BEM, EF, and CEM have become a hybrid of mediation and arbitration⁷⁸ in which mediators unilaterally preempt parties' options rather than simply withdrawing when they believe a moral line has been crossed. BEM additionally expects mediators to enforce agreements the parties may no longer endorse, and to share confidential patient information, thereby infringing two other core ethical principles of mediation.

Mediation's core values are not arbitrary edicts. They derive from long-tested experience with what helps people in conflict to trust a process that can help them better understand their own priorities and to arrive at genuinely durable resolutions. Beyond bioethics, mediation should be available throughout healthcare organizations, not just for patient-provider issues. Administrations sometimes clash with medical staffs; intra- and inter-departmental collisions can be costly and counterproductive; nurses and allied staff may have disputes with colleagues or other providers; senior leadership may have in-house conflicts that must, per the Joint Commission, be managed appropriately.⁷⁹ Conflict can harm quality and safety, precipitate staff burnout,

⁷⁸ Antommaria, *supra* note 12, at 45–46.

⁷⁹ The Joint Commission (TJC) recognized the need for in-house conflict resolution processes as early as 2009, requiring that hospitals “provide[] a system for resolving

and engender dissatisfaction among patients, families, and staff. Thus, the entire clinical setting is an appropriate venue for high-quality conflict resolution, including mediation, as case studies described elsewhere illustrate.⁸⁰

As a final clarifying note, it is useful to distinguish healthcare's clinical setting from litigation, the most common setting for mediation. The differences are logistical rather than substantive (mediation's core values and processes should be honored regardless of setting), but they are significant enough to require some adaptation. As these have been discussed elsewhere,⁸¹ a few key differences are only briefly summarized here.

In a lawsuit, by the time parties consider mediation, issues are usually fairly well-defined in the plaintiff's complaint. In healthcare the issues usually require considerable exploration before clear(ish) questions are on the table. Analogously, lawsuits are filed after events are fixed and in the past. The relevant facts have usually been gathered, although they and their evidence may be disputed. In healthcare the facts are anything but fixed. Conflicts, and the realities in which they are embedded, may be rapidly shifting under foot as patients' conditions change, e.g., or as inter-departmental relationships evolve.

Litigation-mediation typically follows a fairly standard format (orientation, openings, caucuses, etc.), and is carried out during one, perhaps very long session, occasionally with follow-up sessions for complex suits. In the clinical setting, such marathons are usually not possible, desirable, or even useful. Instead, the mediation is commonly a series of briefer conversations with varying combinations of people, typically spread over a number of days.⁸² After all, patients with complex issues are often present for prolonged periods

conflicts among individuals working in the hospital" (LD.01.03.01 EP-7), that "[t]he hospital manage[] conflict between leadership groups to protect the quality and safety of care," that "[t]he hospital has a process that allows staff, patients, and families to address ethical issues or issues prone to conflict," and that "[t]he hospital uses its process to address ethical issues or issues prone to conflict" LD.04.01.03) COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS LD 02.04.01 (THE JOINT COMM'N 2019).

⁸⁰ For examples see Haavi Morreim, *Mediating Healthcare Disputes More, Earlier . . . And Differently: Mediating Directly in the Clinical Setting*, 31 THE HEALTH LAWYER, no. 1, 2018, at 18, 27–28.

⁸¹ Haavi Morreim, *Conflict Resolution in Health Care*, AHLA CONNECTIONS, Jan. 2014, at 28, 28-30; Haavi Morreim, *In-House Conflict Resolution Processes: Health Lawyers as Problem-Solvers*, 26 THE HEALTH LAWYER, no. 3, Feb. 2014, at 10, 13–14; Haavi Morreim, *Story of a Mediation in the Clinical Setting*, 27 J. CLINICAL ETHICS no. 1, 2016, at 43, 46; Haavi Morreim, *Conflict Resolution in the Clinical Setting: A Story Beyond Bioethics Mediation*, 43 J. L. MED. & ETHICS 843, 852 (2015).

⁸² Morreim, *Conflict Resolution in the Clinical Setting*, *supra* note 81, at 852; Morreim, *Story of a Mediation*, *supra* note 81, at 48.

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and staff or administrative disputes likewise permit an evolving conversation over time. Clinical mediation is thus highly flexible, not tied to any particular format.

In litigation, a successful settlement typically resolves all the issues in a legally enforceable contract. Neither is common in healthcare. An agreement may be simply "here is what we will try next," or "we will continue the conversation after we get that second opinion," or "for now we will do X," with an understanding that some questions may remain unresolved, and that changing conditions can trigger a need for further negotiation. In most cases there is no formal contract, and the only enforceability is the parties' genuine willingness to embrace and implement the proposed solution. If parties' most important underlying concerns are not unearthed and addressed, an apparent "agreement" will often fall apart, and quickly. As a result, while litigation-mediation is often evaluative in style, clinical-setting mediation must be highly facilitative.

In the end, healthcare would be well-served by an abundance of high-quality, user-friendly conflict resolution processes, one of which assuredly should be mediation.⁸³ Bioethicists could be one source for that service, yet it will be important to distinguish mediation services from guidance-consult services, and to remain faithful to mediation's core principles of practice and ethics: confidentiality, neutrality, and self-determination.

⁸³ Randall C. Jenkins, Gregory Firestone, Kari I. Aasheim & Brian W. Boelens, *Mandatory Pre-Suit Mediation for Medical Malpractice: Eight-Year Results and Future Innovations*, 35 CONFLICT RESOL. Q. 73, 83–88 (2017).

